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4 000	Initial Comments A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on August 23, 2019. the facility was found not to be in substantial compliance. Survey Dates: August 20, 2019 through August 23, 2019. Survey Census: 81	4 000		
4 101	11-94.1-22(c) Medical record system (c) The following information shall be obtained and entered in the resident's record at the time of admission to the facility: (1) Personal information such as name, date, and time of admission, date and place of birth, citizenship status, marital status, social security number, or an admission number that can be used to identify the resident without use of name when the latter is desirable; (2) Name and address of next of kin, legal guardian, surrogate, or representative holding a power of attorney; (3) Sex, height, weight, race, and identifying marks; (4) Reason for admission or referral; (5) Language spoken and understood; (6) Information relevant to religious affiliation, if any; (7) Admission diagnosis, summary of prior medical care with listing of physicians	4 101		10/4/19

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4 101	Continued From page 1 providing care, recent physical examination, tuberculosis status, and physician's orders; and (8) Advanced directives, as applicable. This Statute is not met as evidenced by: Based on record review (RR) and interview, the facility failed to have a process in place to establish, maintain, and implement written policies and procedures regarding the resident's right to formulate an advance directive (AD) for 10 of 18 residents ((R) R16, R27, R37, R41, R42, R43, R55, R67, R68, and R79) selected for review. The facility's focus was to have a POLST(Provider Orders for Life Sustaining Treatment) rather than an AD. A POLST is a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency. A POLST form is not an AD. Findings include: 1. On 08/21/19 at 01:44 PM, RR for R37 reflected no AD on record for R37. On 08/21/19 at 09:40 AM, interview with Social Service Designee (SSD) who stated she is unaware of the need for residents to have an AD while at the facility. On 08/21/19 at 10:46 AM, interview with Facility Administrator (FA) who confirmed they do not have a process in place for residents to formulate an AD. FA said he will work with the staff to develop a process for AD's . 2. Additional RR revealed no AD or offer to formulate one for R42, and R79.	4 101	Corrective Actions Done 1. Social Worker designee talked to resident representative of residents # 16, 27, 37, 41, 42, 55, 67, 68 and 79 by phone or in person and discuss information re-advance directives. This is documented on the electronic medical record. 2. Social Service and nursing staff checked all resident records to determine those with Advance Directives on file. 3. Advance Directive information is added in our Residents Handbook. 4. Upon resident admission, Social Worker designee will ask resident or resident representatives if they: - already have Advance Directive and to provide us a copy for our record. - would want to know more about Advance directives. 5. Letter will be given to current residents or their representatives informing them about advance directive compliance and to contact our Social Worker for more information. System change and Monitoring System to Ensure Deficient Practice will not Recur 1. Our facility□s Advance Directives	

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4 101	Continued From page 2 3. On 08/21/19 RR for R27 revealed a POLST in the medical record, but no AD. On 08/21/19 at 02:20 PM FA provided a document that listed all resident's indicating if they had a POLST or AD. R27 was listed as not having an AD. 4. On 08/20/19 RR for R41 revealed a POLST signed by R41's sister in the record, but no AD. On 08/21/19 at 02:20 PM FA provided a document that listed all resident's that indicated if they had a POLST or AD. R41 was listed as not having an AD. R41 is cognitively not able to comprehend a discussion about health care directives and family was unavailable for further discussion. 5. 08/21/19 RR for R43 revealed a POLST in the record, but no AD. On 08/21/19 at 02:20 PM FA provided a document that listed all resident's that indicated if they had a POLST or AD. R43 was listed as not having an AD. R43 was not available for further interview as she was transferred to an acute care hospital in the evening of 08/20/19 at 07:10 PM. 6. 08/21/19 02:14 PM RR for R68 revealed a POLST in the medical record, but no AD. On 08/21/19 at 02:20 PM FA provided a document that listed all resident's that indicated if they had a POLST or AD. R68 was marked as not having an AD. 7. RR completed for R16, R67 and R55 found that they did not have an advanced directive (AD) in their clinical records. 8. On 08/21/19 10:46 AM, the FA brought the	4 101	Policy was reviewed and revised. 2. Upon admission, Social worker designee will ask resident or their resident representative about existence of any advance directive. 3. Document will be signed signifying their wishes and confirm that Advance Directive information was discussed. 4. If resident has made his/her directives, facility will request a copy of the Advance Directive or Power of Attorney for health for our records. 5. Care plan team will discuss residents advance directives at least annually and documented on the medical record. 6. Social Service staff will keep a list of residents with Advance Directives on file to be updated as necessary.	

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4 101	Continued From page 3 facility's revised 04/01/19 Advance Directive (AD) Policy Statement. This policy stated: "5. The care plan team will review annually with the resident his or her advance directives to ensure that they are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument (MDS)." On 08/21/19 at 10:46 AM, interview with FA, who confirmed they do not have a process in place for residents to formulate an AD. FA said he will work with his staff to develop a process for AD's.	4 101		
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on observation, record review (RR) and interview, the facility failed to develop a comprehensive care plan (CP)to meet the needs of four of four residents (R)16,R33, R55, R68 sampled. The facility failed to include the use of a back brace in R68's CP, failed to CP activities/sensory stimulation for R33 and R55, and failed to CP a skin tear for R16. As a result of this deficient practice there was potential that R16,R33, R55, and R68 would not have their needs met and not meet their highest practicable physical, mental and psychosocial well-being. Findings include:	4 174	Corrective Actions Done 1. Plan of care for resident #68 was reviewed and revised by interdisciplinary team. 2. Cross Reference tag 4178 Plan of Correction 3. Comprehensive activity care plan for residents # 33 and 55 were done based on their past interests, preferred activity and current physical and psychological condition. 4. Activity provided a radio on the bedside of resident #33 and set on a	10/4/19

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4 174	Continued From page 4 1. R68 was a 70-year-old female admitted on 07/05/19. She had history of limited mobility resulting from right hip surgery sustained in a fall, and subsequently diagnosed with wedge compression (pushing on spinal cord) fracture T9-10 vertebrae (middle of back), and severe spinal stenois (narrowing of the spinal canal) resulting in paralysis of the lower body and legs. R68's discharge summary from the acute care hospital read, the condition was "likely to be a permanent disability." One of the discharge goals was to "train upper body strength," and to use a "thoracic lumbar sacral orthosis (TLSO) brace when bearing weight." The TLSO brace is used to stabilize the spine for healing and decrease pain. RR revealed R68 received physical therapy (PT) from 07/06/19 to 07/26/19. The "occupational therapy (OT) discharge summary" included a short-term goal of "Patient will tolerate sitting for 30 minutes upright in supported sitting with TLSO in place to complete ADL (activities of daily living) such as eating, grooming facilitating increased ADL tasks. It also included the goal that the "patient will tolerate TLSO donned (put on) by educated caregivers." On 08/20/19 at 10:00 AM observed R68 lying on her back with the head of the bed (HOB) slightly elevated. R68 appeared comfortable and was visiting with family. She did not have a brace on. On 08/20/19 at 12:45 PM, observed staff member preparing R68 for lunch by raising the HOB in a sitting position to eat. R68 told staff to stop raising the bed when it became painful for her. The HOB was elevated less than 45 degrees. R68 did not have a TLSO brace on. Interviewed family member at that time who said R68's, "not getting	4 174	music station for sensory stimulation. 5. Activity staff will visit bedfast residents every day for socialization or provide sensory stimulation. All activities provided will be documented on the resident□s medical record. 6. Activity staff and MDS nurses reviewed the care plan of the rest of the residents. 7. Residents who are mostly bedfast or have passive activity participation will have individualized plan of care for socialization and minimize decline cognitively, physically and psychologically. 8. Charge nurse made an episodic plan of care for skin tear on the leg of resident # 16. System change and Monitoring System to Ensure Deficient Practice will not Recur 1. Cross Reference tag 4178 Plan of Correction 2. Activity staff will interview resident or resident representative upon admission to learn about residents past interests and preferences. 3. Resident will be informed of the activities planned for the day and invite/encourage them to join for their socialization. 4. One on one activity and room visits will be provided by activity staff, volunteers and nursing staff to residents who are unable to join group activities. Conversation, singing or gentle exercise will be provided for socialization and sensory stimulation.	

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4 174	Continued From page 5 physical therapy (PT) anymore due to minimal progress." She said R68 could not tolerate sitting in a chair upright, and was now always in bed. On 08/21/19 at 10:43 AM, observed R68 sleeping in bed with TLSO brace on. HOB was slightly elevated. On 08/21/19 at 03:29 PM during an interview with PT1, reviewed R68's chart and confirmed the recommendation that R68 was to have the brace (TLSO) applied by nursing staff for meals to help reduce pain and to tolerate the HOB up higher for meals and ADL's. PT1 explained, "When a resident is discharged from PT, we make recommendations to nursing for maintenance. We have a restorative care program (RCP) and restorative nursing aides (RNA) to assist with the recommendations, and do the exercises" RR of the occupational therapy (OT) discharge summary for dates of service 07/06/10 to 07/26/19 signed on 07/30/19 included the following: a. "Status: Patient and Caregiver Training: Instructed patient in safe task completion... specifically education to donn (put on) TLSO in bed to increase sitting tolerance, positioning, functional reach for positional adjustment for comfort in order to facilitate improved performance during functional activities, increase safety and reduce the risk of further medical complications that may result in impairments/conditions and prevent decline from current level of skill ..." b. "Discharge Recommendations: TLSO in bed to support when sitting for meals and activities as needed. Equipment recommended upon discharge: TLSO."	4 174	5. TV and/or radio will be provided to resident□s who are bedfast or refusing to come out of their room and set on the music or program of their choice. 6. Effective immediately all staff including outside providers will report to the charge nurse, any change in condition observed on the resident. 7. These changes will be documented on the progress notes and plan of care will be initiated.	

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4 174	Continued From page 6 Review of the facility's policy titled, "Restorative Service Policy" dated 01/04/19. states "Licensed rehabilitation (rehab) personnel will communicate to nursing staff in writing, all resident care like use of braces, splints, or mobility devices...to maintain progress of resident's rehabilitation," and "once a resident has met his/her care plan goals, a licensed professional can either discontinue or initiate a maintenance program which either nursing or restorative aides will implement to assure that the resident maintains his/her functional and physical status." The policy also states, "the rehabilitation goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services. RR of 68's comprehensive care plan included the problems of Pain, and self-care/ADL (activities of daily living, e.g.. toileting, eating, grooming) deficit related to limited mobility requiring assistance. The goals included, " will not exhibit expressions of pain....or verbalization of pain... 30 minutes to one hour after receiving pain medication, " ... and "will be able to perform basic self care tasks with minimum...assistance." Approaches/ interventions identified to reach these goals did not include wearing ease sitting tolerance. 2. Random observations of R33 during the survey found the resident in bed for the majority of the time with no activities observed for her. On 08/20/19 at 11:03 AM, R33 was seen in bed since the morning, and observed talking non-sensically to herself. On 08/21/19 at 03:41 PM, R33 was observed in bed mumbling softly and fidgeting with her hands over and over. The resident was not brought out by the staff to attend the daily group activities either, but remained in her bed with no music or television on.	4 174		

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4 174	Continued From page 7 Record review found that R33 had diagnoses of vascular dementia with severely impaired decision making, unclear mumbled speech, episodes of hitting, spitting, cursing, screaming, yelling and swearing during care. One of R33's care plan for her cognitive deficit stated she was dependent on the staff for sensory stimulation related to her vascular dementia. Other care plans included R33's self care deficit related to limited mobility resulting from atrophy of her muscles of multiple sites, behavioral disturbances, assistance in all of her activities of daily living (ADLs), and the use of a wheelchair as her mobility device. There was also a care plan for mood and behavior, but further review found no comprehensive care plan for activity-related and/or sensory stimulation care. R33's clinical record noted visits by activity staff that daily one to one visits including verbal, tactile, and "listening to music" approaches were being provided to her. None of this however, was observed during random observations of the resident. On 08/22/19 at 02:04 PM, an interview with the Activities Coordinator (AC) was done. The AC said R33 could not tolerate coming out of her room because of her behaviors and dementia. The AC said she did, "verbal, and 1:1 and every day room visit I spend about 5-10 minutes, because there are no responses. Any time I have time for them, that's when I do the tactile--breakfast time or lunch time. I have no specific time for them. When I come early in the morning, that's when I visit them for those residents that are not coming out." When the AC was asked to provide the activity/sensory care plan for R33, the AC only kept stating, "(R33)	4 174		

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dependent on staff for sensory stimulation," but was unable to produce a resident-centered care plan for the activities/sensory stimulation being provided to the resident.

3. Similarly, for R55, this resident observed on 08/20/19 at 11:16 AM, sitting up in bed, saying, "come here, come here." R55 could state his name and understand some words spoken to him. He did not have any music or television on, but would call out to people who came into his room or saw them passing by in the hallway.

Although the resident was receiving physical therapy (PT) due to hemiplegia affecting his right side and generalized muscle weakness, and with a stage 2 sacral pressure injury, the resident was observed sitting in his bed looking at people pass by in the hallway.

On 08/22/19 at 08:53 AM, during an interview with certified nurse aide (CNA) 27, she said R55 does exercises while in bed but they did not want to get him up until the pressure injury healed (it was mostly healed).

During an interview of AC, she stated she offered music, exercises, "talking to him--he understands simple English. I offered him the radio," and acknowledged there was not much going on for him. The AC said, "Whatever we do to him, we give to the MDS coordinator, we don't have a set one (care plan for activities), it's all integrated with the cognition." The AC verified she had not developed a care plan for R55 and said the reality orientation she did was the weather for the day. Yet during the AC's visit with R55 on 08/23/19 at 08:23 AM, she engaged the resident and had him to upper body exercises with simple commands and stated he likes to pray, read his bible and

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4 174	Continued From page 9	4 174		

church members visit him. The AC acknowledged these approaches were being implemented, but there was no care plan for it.

On 08/22/19 at 03:11 PM, the Assistant Director of Nursing (ADON) stated the development of resident-centered care plans, "Is open to everyone, not just for nursing." The ADON acknowledged the AC or others could have developed a care plan for residents receiving sensory stimulation or other individualized activities based on resident preference.

4. On 08/20/19 at 10:41 AM, during the initial tour, R16 was on one-to-one monitoring with a nurse aide watching over him. R16 was found to have a skin tear on his right lower leg. R16, who is on hospice care, had been seen by the hospice nurse that morning who then assessed and dressed the skin tear. The hospice nurse stated sometimes due to the resident's unsteady gait, may have gotten the right shin skin tear.

On 08/22/19 at 09:56 AM, during an interview with the ADON, she said it would be an episodic or "paper" care plan developed. Concurrent record review did not find a care plan for this newly identified skin tear.

On 08/22/19 at 10:15 AM, an interview was done with the hospice nurse who found and dressed 16's skin tear. She stated she did not get an order from the doctor, "because it's a skin flap and it's better to keep the wound open to air and I know him to be impulsive. I only covered it with a dry dressing and put the flap in there, it will be easier to heal." The hospice nurse said her handwritten notes measured the skin tear to be 1.3 x 0.5 centimeters (cm) to R16's right shin,

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4 174	Continued From page 10 and noted the skin flap was placed back on with the use of normal saline to clean it and covered it with a dry dressing. The hospice nurse said she did not convey to the facility's nursing staff that she did a wound treatment/intervention on the day she found it on 08/20/19. Based on observation, record review (RR) and interview, the facility failed to develop a comprehensive care plan (CP) to meet the needs of four of four residents (R)16,R33, R55, R68 sampled. The facility failed to include the use of a back brace in R68's CP, failed to CP activities/sensory stimulation for R33 and R55, and failed to CP a new skin tear for R16. As a result of this deficient practice there was potential that R16, R33, R55, and R68 would not have their needs met and not meet their highest practicable physical, mental and psychosocial well-being. Findings include: 1) R68 was a 70-year-old female admitted on 07/05/19. She had history of limited mobility resulting from right hip surgery sustained in a fall,	4 174		

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4 174	Continued From page 11 and subsequently diagnosed with wedge compression (pushing on spinal cord) fracture T9-10 vertebrae (middle of back), and severe spinal stenois (narrowing of the spinal canal) resulting in paralysis of the lower body and legs. R68's discharge summary from the acute care hospital read, the condition was "likely to be a permanent disability." One of the discharge goals was to "train upper body strength," and to use a "thoracic lumbar sacral orthosis (TLSO) brace when bearing weight." The TLSO brace is used to stabilize the spine for healing and decrease pain. RR revealed R68 received physical therapy (PT) from 07/06/19 to 07/26/19. The "occupational therapy (OT) discharge summary" included a short-term goal of "Patient will tolerate sitting for 30 minutes upright in supported sitting with TLSO in place to complete ADL (activities of daily living) such as eating, grooming facilitating increased ADL tasks. It also included the goal that the "patient will tolerate TLSO donned (put on) by educated caregivers." On 08/20/19 at 10:00 AM observed R68 lying on her back with the head of the bed (HOB) slightly elevated. R68 appeared comfortable and was visiting with family. She did not have a brace on. On 08/20/19 at 12:45 PM, observed staff member preparing R68 for lunch by raising the HOB in a sitting position to eat. R68 told staff to stop raising the bed when it became painful for her. The HOB was elevated less than 45 degrees. R68 did not have a TLSO brace on. Interviewed family member at that time who said R68's, "not getting physical therapy (PT) anymore due to minimal progress." She said R68 could not tolerate sitting in a chair upright, and was now always in bed.	4 174		

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4 174	Continued From page 12 On 08/21/19 at 10:43 AM, observed R68 sleeping in bed with TLSO brace on. HOB was slightly elevated. On 08/21/19 at 03:29 PM during an interview with Physical Therapist (PT)1, reviewed R68's chart and confirmed the recommendation that R68 was to have the brace (TLSO) applied by nursing staff for meals to help reduce pain and to tolerate the HOB up higher for meals and ADL's. PT1 explained, "When a resident is discharged from PT, we make recommendations to nursing for maintenance. We have a restorative care program (RCP) and restorative nursing aides (RNA) to assist with the recommendations, and do the exercises" RR of the occupational therapy (OT) discharge summary for dates of service 07/06/10 to 07/26/19 signed on 07/30/19 included the following: a. "Status: Patient and Caregiver Training: Instructed patient in safe task completion... specifically education to donn (put on) TLSO in bed to increase sitting tolerance, positioning...to facilitate improved performance during functional activities, increase safety and reduce the risk of further medical complications that may result in impairments/conditions and prevent decline from current level of skill ..." b. "Discharge Recommendations: TLSO in bed to support when sitting for meals and activities as needed. Equipment recommended upon discharge: TLSO." Review of the facility's policy titled, "Restorative Service Policy" dated 01/04/19. states "Licensed rehabilitation (rehab) personnel will communicate to nursing staff in writing, all resident care like use of braces, splints, or mobility devices...to maintain	4 174		

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4 174	Continued From page 13 progress of resident's rehabilitation," and "once a resident has met his/her care plan goals, a licensed professional can either discontinue or initiate a maintenance program which either nursing or restorative aides will implement to assure that the resident maintains his/her functional and physical status." The policy also states, "the rehabilitation goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services. RR of 68's comprehensive care plan included did not include applying the TLSO brace to increase sitting tolerance, reduce pain, or to help maintain ADL's. On 08/23/19 at 12:21 PM during an interview with Registered Nurse (RN)11, asked if she knew anything about R68's TLSO brace. RN11 said, "I passed by R68's room one day while doing rounds and was called into the room. R68 had the brace on and one of the Occupational Therapists (OT) told me R68 might do better if the brace was used when sitting up in bed and might be able to tolerate sitting up longer." RN11 did not recall who the OT staff was. Inquired how OT usually communicates the RCP. RN said, "When the resident is ending therapy, they give us a therapy communication form with directions...The RN's and RNA's sign off they are aware of the plan and have been educated. Then we add it to the Care Plan (CP), and the RNA task list." RN11 said they did not get a therapy communication form for R68. On 08/23/19 at 11:57 AM during an interview with Director of Nursing (DON) reviewed the OT discharge summary. The DON confirmed OT did not communicate to Nursing, and stated, " They usually give us a form. That didn't happen."	4 174		

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4 174	Continued From page 14 2) Cross reference tag 676. The facility failed to provide R68 with the recommended therapy of applying the TLSO brace when elevated in bed for meals and performing ADL's. Nursing was to apply the brace to decrease pain and increase sitting tolerance so R68 could have increased participation in ADL's and improve quality of life. 3) Random observations of R33 during the survey found the resident in bed for the majority of the time with no activities observed for her. On 08/20/19 at 11:03 AM, R33 was seen in bed since the morning, and observed talking non-sensically to herself. On 08/21/19 at 03:41 PM, R33 was observed in bed mumbling softly and fidgeting with her hands over and over. The resident was not brought out by the staff to attend the daily group activities, but remained in her bed with no music or television on. RR found that R33 had diagnoses of vascular dementia with severely impaired decision making, unclear mumbled speech, episodes of hitting, spitting, cursing, screaming, yelling and swearing during care. One of R33's CP's for her cognitive deficit stated she was dependent on the staff for sensory stimulation related to her vascular dementia. Other CP's included R33's self care deficit related to limited mobility resulting from atrophy of her muscles of multiple sites, behavioral disturbances, assistance in all of her ADLs, and the use of a wheelchair as her mobility device. There was also a CP for mood and behavior, but further review found no comprehensive care plan for activity-related and/or sensory stimulation care. R33's clinical record noted visits by activity	4 174		

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4 174	Continued From page 15 staff that daily one to one visits including verbal, tactile, and "listening to music" approaches were being provided to her. None of this however, was observed during random observations of the resident. On 08/22/19 at 02:04 PM, an interview with the Activities Coordinator (AC) was done. The AC said R33 could not tolerate coming out of her room because of her behaviors and dementia. The AC said she did, "verbal, and 1:1 room visits. I spend about 5-10 minutes, because there are no responses. Any time I have time for them, that's when I do the tactile--breakfast time or lunch time. I have no specific time for them. When I come early in the morning, that's when I visit residents that are not coming out." When the AC was asked to provide the activity/sensory CP for R33, the AC only kept stating, "R33's dependent on staff for sensory stimulation," but was unable to produce a resident-centered CP for the activities/sensory stimulation being provided to the resident. 4) Similarly, for R55, this resident observed on 08/20/19 at 11:16 AM, sitting up in bed, saying, "come here, come here." R55 could state his name and understand some words spoken to him. He did not have any music or television on, but would call out to people who came into his room or saw them passing by in the hallway. Although the resident was receiving PT due to hemiplegia affecting his right side and generalized muscle weakness, and with a stage 2 sacral pressure injury, the resident was observed sitting in his bed looking at people pass by in the hallway. On 08/22/19 at 08:53 AM, during an interview	4 174		

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4 174	Continued From page 16	4 174		

with certified nurse aide (CNA) 27, she said R55 does exercises while in bed but they did not want to get him up until the pressure injury healed (it was mostly healed).

During an interview with AC, she stated she offered music, exercises, "talking to him--he understands simple English. I offered him the radio," and acknowledged there was not much going on for him. The AC said, "Whatever we do with him, we give to the MDS coordinator, we don't have a set one (CP for activities), it's all integrated with the cognition." The AC verified she had not developed a CP for R55 and said the reality orientation she did was the weather for the day. Yet during the AC's visit with R55 on 08/23/19 at 08:23 AM, she engaged the resident and had him do upper body exercises with simple commands and stated he likes to pray, read his bible and church members visit him. The AC acknowledged these approaches were being implemented, but there was no CP for it.

On 08/22/19 at 03:11 PM, the Assistant Director of Nursing (ADON) stated the development of resident-centered CPs, "Is open to everyone, not just for nursing." The ADON acknowledged the AC or others could have developed a CP for residents receiving sensory stimulation or other individualized activities based on resident preference.

5) On 08/20/19 at 10:41 AM, during the initial tour, R16 was on one-to-one monitoring with a nurse aide watching over him. R16 was found to have a skin tear on his right lower leg. R16, who is on hospice care, had been seen by the hospice nurse that morning who then assessed and dressed the skin tear. The hospice nurse stated he may have gotten the skin tear because he has

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4 174	Continued From page 17 an unsteady gait sometimes. On 08/22/19 at 09:56 AM, during an interview with the ADON, she said it would be an episodic or "paper" CP developed. Concurrent record review did not find a CP for this newly identified skin tear. On 08/22/19 at 10:15 AM, an interview was done with the hospice nurse who found and dressed 16's skin tear. She stated she did not get an order from the doctor, "because it's a skin flap and it's better to keep the wound open to air and I know him to be impulsive. I only covered it with a dry dressing and put the flap in there, it will be easier to heal." The hospice nurse said her handwritten notes measured the skin tear to be 1.3 x 0.5 centimeters (cm) to R16's right shin, and noted the skin flap was placed back on with the use of normal saline to clean it and covered it with a dry dressing. The hospice nurse said she did not convey to the facility's nursing staff that she did a wound treatment/intervention on the day she found it on 08/20/19.	4 174		
4 178	11-94.1-44(b) Specialized regabilitation services (b) A written rehabilitative plan of care integrated into the overall plan of care, shall be provided that is based on the attending physician's, physician assistant's, or APRN's orders and assessment of a resident's needs in regard to specialized rehabilitative procedures. It shall be developed by the rehabilitative staff and incorporated in, and regularly reviewed in conjunction with, the overall care plan for the resident.	4 178		9/30/19

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4 178	Continued From page 18 This Statute is not met as evidenced by: Based on observations, interviews and record review (RR) the facility failed to provide the services to one of one Resident (R)68 sampled to ensure that she maintained her ability to carry out activities of daily living (hygiene-bathing, grooming, toileting, dining). The staff did not apply a back brace that was recommended to decrease pain and provide support so she could maintain and improve doing her activities of daily living with as little pain as possible. As a result of this deficient practice, there was the potential that R68 may not reach her fullest potential and may have a decline in functional condition. Findings include: R68 was a 70-year-old female admitted on 07/05/19. She had history of limited mobility resulting from right hip surgery sustained in a fall, and subsequently diagnosed with wedge compression (pushing on spinal cord) fracture T9-10 vertebrae (middle of back), and severe spinal stenosis (narrowing of the spinal canal) resulting in paralysis of the lower body and legs. R68's discharge summary from the acute care hospital read, the condition was "likely to be a permanent disability." One of the discharge goals was to "train upper body strength," and to use a "thoracic lumbar sacral orthosis (TLSO) brace when bearing weight." The TLSO brace is an externally applied corset type brace recommended to stabilize the spine for healing and decrease pain. On 08/20/19 at 10:00 AM observed R68 lying on her back with the head of the bed (HOB) slightly elevated. R68 appeared comfortable and was visiting with family. She did not have a brace on.	4 178	Corrective Actions Done 1. MDS nurse reviewed and revised the plan of care for resident # 68. 2. Plan of care included the use of thoraco-lumbar sacral orthosis brace when sitting to stabilize the spine and reduce pain. 3. DON, MDS Coordinator, Administrator and therapist had a meeting on 9/4/19 and discuss ways to improve coordination of services 4. Effective immediately, therapists will join our stand up meetings to communicate progress of rehabilitation of the resident to the interdisciplinary team at least every week. 5. Communication to nursing staff will be in writing that includes the current level of ADL assistance, use of mobility device, splints and braces. System change and Monitoring System to Ensure Deficient Practice will not Recur 1. To continue with the progress of rehabilitation of the resident, therapists will communicate to interdisciplinary team in writing, all necessary care like the current level of functional mobility, ADL□s and/or use of DME, orthosis, brace or prosthesis at least every week. 2. Upon completion of rehab, therapist will give a written recommendation to MDS staff and nursing staff to maintain comfort and physical ability of resident. 3. Recommendations will be relayed to	

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4 178	Continued From page 19 On 08/20/19 at 12:45 PM, observed staff member preparing R68 for lunch by raising the HOB in a sitting position to eat. R68 told staff to stop raising the bed when it became painful for her. The HOB was elevated less than 30 degrees. R68 did not a TLSO brace on. Interviewed a family member at that time who said R68 was no longer getting physical therapy (PT) because she wasn't making progress. She said R68 had not been able to tolerate sitting in a chair, so was always in bed now. On 08/21/19 at 10:43 AM, observed R68 sleeping in bed with TLSO brace on. HOB elevation angle was at approximately 30 degrees. RR of R68's care plan (CP) did not include any reference to a TLSO brace. RR revealed a piece of paper in the front of R68's chart dated "August 21, 2019." The following was typed on the piece of paper: "TLSO Clarification-Patient to wear TLSO when sitting or out of bed. Questions/Concerns please contact the Rehab (rehabilitation) department." The note was not timed or signed. RR of the occupational therapy (OT) discharge summary for dates of service 07/06/10 to 07/26/19 signed on 07/30/19 included the following: a. "Status ... Patient and Caregiver Training: Instructed patient in safe task completion. Task modification and compensatory strategies specifically education to donn (put on) TLSO in bed to increase sitting tolerance, positioning, functional reach for positional adjustment for comfort in order to facilitate improved performance during functional activities, increase safety and reduce the risk of further medical	4 178	attending physician and included in the comprehensive plan of care for all nursing staff to follow. 4. Training on the use of an appliance will be provided by therapist to nursing staff if necessary. 5. MDS and charge nurses will be responsible to monitor and supervise caregivers to make sure that the plan of care is followed and implemented.	

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4 178	Continued From page 20 complications that may result in impairments/conditions and prevent decline from current level of skill ..." b. "Discharge Recommendations: TLSO in bed to support when sitting for meals and activities as needed. Equipment recommended upon discharge: TLSO." On 08/21/10 at 11:00 AM, during an interview with Registered Nurse (RN)11, asked what she knew about R68's TLSO brace. RN stated, she's supposed to have it on when she's sitting up in bed for meals. Asked if staff were expected to document when the brace was applied, she replied, "Yes." Reviewed Nursing Progress notes that revealed staff did not consistently document the application of the TLSO brace. RN11 stated she thought, "some staff may feel they shouldn't put it on if she's (R68) in pain." On 08/21/19 at 03:29 PM during an interview with PT1, she reviewed R68's chart and confirmed the recommendation that R68 was to have the brace applied by nursing staff for meals to help reduce pain and be able to tolerate the Head of Bed (HOB) up at a higher angle for meals and ADL's. PT1 explained, "When a resident is discharged the rehab staff make recommendations to nursing for maintenance. We have a restorative care program and restorative nursing aides to assist with the recommendations and exercises." On 08/23/19 at 12:21 PM during an interview with RN11,asked if she knew anything about the unsigned typed piece of paper in R68's chart from the rehab department. RN11 said, "I passed by R68's room one day while doing rounds and was called into the room. R68 had the TLSO brace on and one of the OT staff told me R68 might do better if the brace was used when she was sitting	4 178		

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4 178	Continued From page 21 up in bed and might be able to tolerate sitting up longer." RN11 did not recall who the OT staff was. Inquired how OT usually communicates the restorative care plan. RN said, "when the resident is ending therapy, they give us a therapy communication form with directions, and they check off what is recommended. They can also write comments as needed. The RN's and CNA's (Certified Nursing Assistant) sign off they are aware of the plan and have been educated." RN said they did not get one for R68. She stated, "I was on vacation the week after her therapy ended and when I came back, I told them (rehab) I was given a verbal recommendation for the use of the brace but didn't get the form. That's when the typed note was put in the chart." RN11 said she asked why the therapist did not fill out the form and was told the therapist was not comfortable completing the specifics of a recommendation made by another therapist that was not available. Review of the facility's policy titled, "Restorative Service Policy" dated 01/04/19 states "Licensed rehab personnel will communicate to nursing staff in writing, all resident care like use of braces, splints, or mobility devices...to maintain progress of resident's rehabilitation," and "once a resident has met his/her care plan goals, a licensed professional can either discontinue or initiate a maintenance program which either nursing or restorative aides will implement to assure that the resident maintains his/her functional and physical status." The policy also states, "the rehabilitation goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services."	4 178		